NOTICE OF INDEPENDENT REVIEW DECISION

July 9, 2002

RE: MDR Tracking #: M2-02-0636-01
IRO Certificate #: 4326

___has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 28 year old male sustained a work-related injury on ___ when a wrench came loose causing him to fall backwards striking the back of his neck and shoulders. The patient has undergone an MRI of the cervical spine and the shoulders as well as neuro-diagnostics. The patient has been under the care of a chiropractor and has had physical therapy, manipulation under anesthesia and epidural steroid injections. The treating chiropractor has recommended that the patient undergo a pain management program.

Requested Service(s)

Pain management program

Decision

It is determined that the pain management program is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

A chronic pain management program is medically necessary to treat the patient's condition due to the following:

1. The patient has complaints of pain that have been unresponsive to treatment and have been present for 19 months.

2. The patient's pain is interfering with his physical, psychological, social, and vocational functioning.

3. Until the work-related injury, the patient did not have problems.

4. A mental health evaluation identified that the patient was a candidate for the program.

5. Previous treatments appear to have been appropriate for the patient's condition and he has not responded to care.

6. The patient is likely to benefit from the program.

This decision by the IRO is deemed to be a TWCC decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

**If disputing other prospective medical necessity (preauthorization ) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,